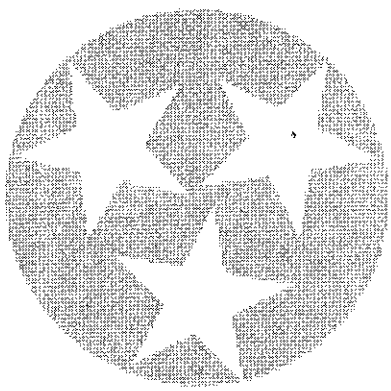
Fiscal Accountability Review (FAR)



Department of Finance and Administration
Division of Intellectual Disabilities Services
Office of Internal Audit

INTRODUCTION

The Office of Internal Audit reports to the Assistant Commissioner of Administrative Services and is functionally divided into the Investigative and the Fiscal Accountability Review (FAR) units.

The FAR unit conducts monitoring on a statewide basis and is guided in this endeavor by:

a) DIDS Policy P-017 Financial Accountability Review (copy provided)
b) DIDS Procedure Manual, which can be viewed at the DIDS website, under the "For Providers" link.
c) The Provider and/or Grant Agreement(s) in effect with the agency.

PROCESS OVERVIEW

Scheduling of Reviews

When agency billing exceeds $300,000/year, you will be contacted and a review scheduled. Agencies are contacted a minimum of two (2) weeks prior to proposed review date, with one to two month's notice preferred. As much as possible, review schedules accommodate the needs of the agency and the reviewer.

Once the review is scheduled, a Confirmation letter is prepared and emailed to the agency which confirms the agreements to be reviewed and the dates agreed upon. This letter also contains a List of Items Needed prior to, and during, the review.

Elements Tested

Service Provision

The objective is to test whether the provider's billings and payments are supported by the agency's documentation of provided services.

When billed units are not adequately supported, questioned costs are cited (rate/unit multiplied by number/units not supported).

Sample size and selection criteria are established in the FAR policy.

Generally, documentation should be legible, pertain to the services, complete, accurate, and be signed rather than initialed. Start/Stop times should also be indicated so hours, shifts and time frames can be established.

Allowable Costs/Cost Principles
This involves a review of agency business practices and do they conform to generally accepted accounting principals.

When agency billing exceeds $500,000/year then an Independent Financial audit is required.

> The current Provider Agreement (eff. Jan 2010 forward) section A.10 Financial and Business Records (d) states:
>
> > Provider recipients of $500,000 or more in aggregate state and federal funds shall undergo, at their expense, an annual independent audit of records in accordance with the requirements of the Tennessee Comptroller of the Treasury. A copy of the report of the annual independent audit will be submitted within 14 days of completion/availability to the DIDS Director of Internal Audit and the applicable Regional Director.

If a report from a independent audit completed within the past twelve (12) months is not available, this is cited as a finding.

Board Minutes
This consists of a review of the agency's minutes of the meetings of the board of directors include any items pertinent to their relationship with DIDS.

Title VI
The objective of this test is to provide assurance that policies and actions taken by the agency do not exclude any person from employment or participation in the program based on the grounds of race, color, or national origin. Test elements include verification of display of the Title VI Poster, submission of the Title VI Self-Survey, the designation of an agency Title VI Coordinator, and whether or not any complaints were filed.

Special Tests and Provisions
The objective here is to identify and then test for agency/program specific requirement(s). Common test elements include:

> Public Accountability: verify Public Accountability poster displayed
>
> Subcontracting: if the agency has subcontractors (not employees) then approval of same from DIDS Central Office is verified
>
> Personal Funds: review the most recent the Quality Assurance (QA) Survey of the agency. If the score in Domain 10 is less than "4" then the FAR reviewer conducts a follow-up inquiry to the status of all individual personal fund issues identified in the QA survey. If all of the identified issues have been resolved, this is reflected in the report.

Deficit Reduction Act: Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires all "covered entities," which is defined as health care providers that receive or make annual Medicaid payments of $5 million or more, to educate employees, contractors or agents about certain fraud and abuse laws.

Agencies who fall within this threshold complete a questionnaire and agency responses are verified while the reviewer is on site. The agency's overall compliance or noncompliance is then reflected in the report.

Report Issue and Response

Once the on site portion of the review is completed, an Exit Conference is conducted with agency staff where initial findings are presented. Then the reviewer prepares and submits a draft report to the Director who finalizes and issues it to the agency.

The agency has 15 Business Days to a Opportunity for Recoupment Review (ORR), as detailed in the current Provider Agreement and/or 30 Calendar Days to submit a Management Response to the report, as detailed in the FAR policy.

The following notification is provided within each report as "Response to Review":

ORR Process
In accordance with the new Provider Agreement an Opportunity for Recoupment Review (ORR) is being provided regarding the findings cited in the Service Provision section of this report. Per clause A.21. Recoupment (b) (ii) the agency must submit a request for an ORR within fifteen (15) business days from the date of the mailing/delivery of this report.

This notification may be accomplished by written correspondence, facsimile transmission or email to:

Email:	**Lee.Vestal@tn.gov**
Fax:	615-401-7681
US Mail:	Lee Vestal, Director of Internal Audit Division of Intellectual Disabilities Services Andrew Jackson Building, 13th Floor 500 Deaderick Street Nashville, Tennessee 37243

If the request for an ORR is not received **by applicable date, 2010**, the Provider has waived its ORR and the Division will proceed to collect the recoupment amount. This will be accomplished as outlined below.

Remediation Process
Per Financial Accountability Review Policy – 017, Section D.6. Remediation, the Provider has 30 days to submit a response to this report. The response may include additional information to justify the billing(s) in question, agree with the finding(s), identify strategies to improve the documentation and billing processes, or a combination of the above. The provider's response will be evaluated and a final resolution memo will be issued regarding the resolution of the findings or recoupment, as applicable.

The agency has until **by applicable date, 2010**., to submit additional information under the Remediation Process. This submission is to be provided to either of the Email, Fax, or US Mail addresses specified above.

If the Remediation Process deadline is not met, a reminder notice will be provided. Failure to respond after the reminder notice can result in the recoupment being accomplished by withholding money from provider payments.

If there are any questions regarding the above, the Director can be reached as outlined above or by phone at (615) 253-8733.

Once the ORR and/or Management Response is received, the Director will evaluate and issue a "Final Resolution" memo. This is the point where any recoupments are effected.

The FAR policy and the current Provider Agreement provide greater detail.